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WEEKLY REPORT

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Congenital Syphilis — United States, 2000

In 1998, CDC initiated intensive efforts to eliminate syphilis from the United States. The following year, the National Syphilis Elimination Plan was launched with the goal of reducing primary and secondary (P&S) syphilis in adults to <0.4 cases per 100,000 population. A decrease in syphilis among women of reproductive age usually is followed by reductions in congenital syphilis (CS) rates. CS occurs when the spirochete *Treponema pallidum* is transmitted from a pregnant woman with syphilis to her fetus. Untreated syphilis during pregnancy may lead to stillbirth, neonatal death, and infant disorders such as deafness, neurologic impairment, and bone deformities. One of the national health objectives for 2000 was to reduce the rate of CS to <40 cases per 100,000 live-born infants (*1*). To evaluate progress toward this goal, the CS rate for 2000 was compared with the rate for 1997, the year before syphilis elimination efforts began. This report summarizes 1997–2000 CS surveillance data, which indicate that CS rates have decreased substantially among most racial/ethnic minority populations and that the elimination of CS in the United States is feasible because of the limited number of cases and highly focal distribution. To increase the percentage of women at risk who receive screening for syphilis during pregnancy, collaborative efforts are needed among health-care providers, health insurers, policymakers, and the public.

CS surveillance data were reported to CDC from the 50 states and the District of Columbia. A case of CS was defined in a live-born infant who 1) manifested typical signs of CS or in whom *T. pallidum* was identified from external lesions, placenta, umbilical cord, or autopsy specimens, or whose mother had a syphilitic lesion at delivery; 2) was born to a woman with untreated or inadequately treated syphilis before or during pregnancy; or 3) was born to a woman with syphilis whose serologic response to penicillin therapy was not documented or was documented to be inadequate (i.e., less than a fourfold decline in titer) and had either a radiologic or cerebrospinal fluid (CSF) test consistent with CS or did not undergo a radiologic or CSF examination for signs of syphilis*. Also included are stillbirths among women with untreated syphilis. Reported CS cases include congenitally exposed infants who lack clinical signs of syphilis. Rates of CS per 100,000 live-born infants were determined from U.S. natality data†.

In 2000, 529 CS cases were reported for a CS rate of 13.4 per 100,000 live-born infants compared with rates of 14.5 in 1999 and 27.8 in 1997, a 7.6% and 51.8% decrease from 1999 and 1997, respectively. In 2000, CS cases were reported from 155 (5.0%) of

*Congenital Syphilis Case Investigation and Report Form 73.126.
†From the National Center for Health Statistics, Vital Statistics: natality tapes 1989–1998.

Congenital Syphilis — Continued

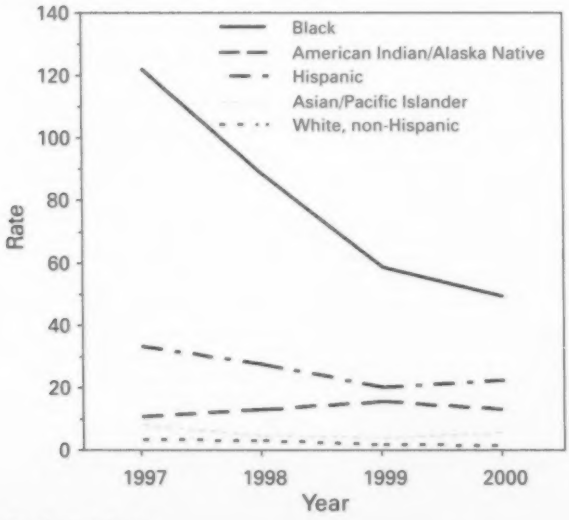
the 3115 U.S. counties. The rate was highest in the South (18.8) compared with the Midwest (9.1), the Northeast (10.1), and the West (11.8).[1] All states reported rates <40 per 100,000 live-born infants, except Arkansas and South Carolina.

In 2000, racial/ethnic minority populations had the highest CS rates (Figure 1): 49.3 among blacks, 22.6 among Hispanics, 13.2 among American Indians/Alaska Natives, and 5.9 among Asians/Pacific Islanders, compared with 1.5 among non-Hispanic whites. Compared with 1997, these rates represent a decline of 59.7% among blacks, 32.5% among Hispanics, 29.8% among Asians/Pacific Islanders, and 58.3% among non-Hispanic whites. Among American Indians/Alaska Natives, the rate increased by 20%; this represented a change from four cases reported in 1997 to five cases in 2000.

In 2000, 83.2% of mothers of infants with CS were aged <35 years, compared with 84.3% in 1997. In 2000, the maternal age group with the highest rate (16.0 per 100,000 live-born infants) of infants with CS was adolescent mothers who delivered at age ≤19 years. This was a decrease of 45.5% from 1997 when the rate was 29.4.

[1] *Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

FIGURE 1. Rate* of congenital syphilis, by year and mothers' race/ethnicity — United States, 1997–2000



* Per 100,000 live-born infants.

Congenital Syphilis — Continued

Among the 529 cases reported in 2000, 434 (82.0%) occurred because the mother had no documented treatment or had received inadequate treatment of syphilis before or during pregnancy. In 123 (28.3%) of these cases, the mother received no prenatal care; in an additional 35 (8.1%), no information on prenatal care was reported. In 36 (6.8%) cases, the mother was treated adequately but did not have an adequate serologic response to therapy, and the infant was evaluated inadequately for CS. In 30 (5.7%) cases, the mother did not have an adequate serologic response to therapy, and the infant's evaluation revealed laboratory or clinical signs of CS; 29 (5.5%) cases occurred for other reasons (Figure 2).

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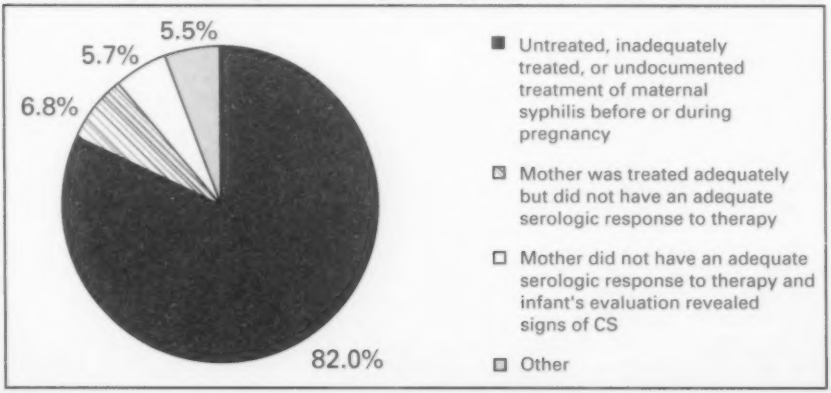
Editorial Note: Substantial progress has been made in eliminating syphilis in the United States. In 2000, the number of CS cases was the lowest since the revised case definition was implemented in 1988, and all but two states met the national health objective for 2000 (*1*). Rates in 2000 declined 51.8% since 1997, the year preceding the start of syphilis elimination efforts. Interventions designed to prevent, detect, and treat syphilis in women of reproductive age may have had a substantial role in these declines. Many of these efforts targeted the racial/ethnic minority populations with the highest CS rates and were located mostly in the South. CS elimination is feasible because of the limited numbers of cases and their highly focal distribution; however, the cornerstone of CS elimination is early detection of syphilis and treatment with penicillin, which is inexpensive, widely available, effective, and safe for the mother and fetus (*2*).

Lack of prenatal care, late or limited prenatal care, and maternal use of illicit drugs are associated with CS (*3–5*). Racial/ethnic minority populations, particularly those in southern states, are disproportionately affected by CS; syphilis rates are higher among these populations than among non-Hispanic whites, and the use of and access to early and comprehensive prenatal care by minority women may be limited. Limited use of and access to prenatal care appear to be the reasons that rates of CS are high among infants

FIGURE 2. Reasons for diagnosis of congenital syphilis (CS) — United States, 2000



Congenital Syphilis — Continued

born to women aged ≤19 years; rates of syphilis are rarely high among these women. Lack of health-care provider adherence to CS screening recommendations also may result in CS. In a 1998 national survey, only 85% of obstetrician/gynecologists reported routinely screening pregnant women for syphilis (*6*). Many providers screen for syphilis only once during pregnancy, usually during the initial clinical visit, despite national recommendations for more frequent testing among women at high risk (e.g., uninsured women, women living in poverty, commercial sex workers, and illicit drug users). Recent trends in U.S. health-care delivery may present substantial barriers to early detection and treatment of syphilis in pregnant women, including the growing number of uninsured women, the limited expansion of prenatal care provided by Medicaid managed care and child health insurance programs, and decreased funding of publicly supported clinics, emergency departments, and other providers that serve poor, uninsured, racial/ethnic minority women and adolescents (*7*).

The findings in this report are subject to at least one limitation. Although the analysis was limited by inconsistent application of the CS case definition and incomplete reporting of asymptomatic CS cases (*8*), these factors were unlikely to have accounted for the declines because no evidence has suggested that application of the case definition for CS or reporting practices changed during this period.

CDC recommends syphilis testing for all women during the early stages of pregnancy. In areas where syphilis prevalence is high or among women at high risk, testing should be done twice in the third trimester, including once at delivery. All women who deliver a stillborn infant after 20 weeks' gestation should be tested. In populations in which use of prenatal care is not optimal, CDC recommends rapid plasma reagin (RPR) card-test screening and treatment (if the RPR-card test is reactive) at the time pregnancy is determined (*9*). Syphilis screening also should be offered in emergency departments, jails, prisons, and other settings that provide episodic care to pregnant women at high risk for syphilis (*10*).

Access to and use of comprehensive prenatal care for women and adolescents who are uninsured or covered by public insurance programs (e.g., Medicaid, migrant health clinics, and the Indian Health Service) should be promoted by communities, health-care providers, and government organizations, and public awareness should be increased about the persistent risk for CS. Care for women with syphilis who use prenatal health services could be improved by increasing providers' adherence to screening and treatment guidelines with reminders and feedback about their prenatal syphilis screening and treatment practices. Ongoing efforts to form and maintain coalitions to develop, implement, and evaluate syphilis elimination activities and interventions also may assist in reducing the prevalence of syphilis among women of reproductive age and, in turn, eliminating CS.

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Prevalence of Hepatitis C Virus Infection Among Clients of HIV Counseling and Testing Sites — Connecticut, 1999

Hepatitis C virus (HCV) is a common chronic bloodborne virus infection that affects an estimated 2.7 million persons in the United States (*1,2*). HCV infection causes an estimated 8,000–10,000 deaths each year from cirrhosis and hepatocellular carcinoma and is the leading reason for liver transplantation. Because injection drug use is a major risk factor for both human immunodeficiency virus (HIV) and HCV transmission, publicly funded HIV counseling and testing sites (HIV CTS) may have a role in HCV prevention (*3,4*). To evaluate the need for HCV services at these sites, the Connecticut Department of Public Health (CDPH) conducted an anonymous HCV seroprevalence study among clients of HIV CTS. This report summarizes the results of this analysis, which indicate that, among clients of these HIV CTS, the prevalence of antibody to HCV (anti-HCV) was 9.8%, compared with 1.3% for HIV, with significantly higher prevalence among clients of substance abuse treatment sites (40.2%), compared with other sites (6.9%). HCV counseling and testing should be integrated into all HIV CTS, especially those associated with substance abuse treatment.

CDPH supports HIV CTS in various public health settings: 12 sites in local health departments, 12 in sexually transmitted disease clinics, 10 in community health centers, and four in family planning clinics. CDPH also supports HIV counseling and testing services for their enrolled clients in 24 substance abuse treatment programs. In all sites, blood specimens are sent to the CDPH virology laboratory for HIV testing.

Blood specimens submitted for HIV testing from HIV CTS over 60 days during April–October 1999 were tested for anti-HCV using an enzyme immunoassay (EIA 2.0, Abbot Laboratories, Abbott Park, Illinois); repeatedly reactive specimens were confirmed by recombinant immunoblot assay (RIBA™ Chiron Corporation, Emeryville, California). Results were linked to information collected as part of HIV counseling, including demographics, HIV infection risk, site of service, and history of previous HIV testing. Clients

Prevalence of Hepatitis C Virus Infection — Continued

who were tested for HIV using oral fluid or blood collected on filter paper were not included in the study. Multivariate analysis was performed using the Proc Logistic function of SAS. CDPH's Human Investigations Committee approved this project.

Of 2801 specimens submitted for HIV testing during the study period, 2133 (76.2%) peripheral venous blood samples were tested for anti-HCV. Of these, 210 (9.8%) were confirmed positive for anti-HCV, 27 (1.3%) for HIV, and seven (0.3%) for both HCV and HIV. Risk factor data were missing for 87 samples (four were anti-HCV positive), and were excluded from further analysis. Among 1852 persons tested at HIV CTS not associated with substance abuse treatment, 128 (6.9%) had specimens positive for anti-HCV (Table 1), compared with 78 (40.2%) of 194 persons tested at HIV CTS associated with substance abuse treatment (Table 2).

Among persons tested at HIV CTS not associated with substance abuse treatment (Table 1), the prevalence of HCV infection was highest (65.3%) among injection drug users (IDUs) (i.e., persons reporting that they had self-injected or received an injection with a needle of a nonprescription drug or substance since 1978). IDUs composed 5.5% of persons tested and accounted for 51.6% of HCV-infected persons in these settings. Among non-IDUs, those aged ≥40 years had the highest prevalence of HCV infection (9.2%). HCV infection among clients of these sites was associated independently with injection drug use, previous HIV testing, older age, not graduating from high school, and low income (<$10,000 per year). No significant association was found between HCV infection and race/ethnicity, sex, or HIV status.

Among persons tested in HIV CTS associated with substance abuse treatment, the prevalence of HCV infection was highest among IDUs (67.8%). Non-IDUs in substance abuse treatment, many with a history of polysubstance abuse, including alcohol, still had a substantially higher HCV infection rate (16.3%) than expected in the general population (*2*), especially among those aged ≥40 years (36.0%). HCV infection among these clients was associated independently only with IDUs and older age groups.

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Editorial Note: The findings in this report indicate that HIV CTS may be important settings to identify persons with risk factors for HCV. More persons seeking services in these programs in Connecticut had HCV infection than HIV infection. The high prevalence of HCV infection among both IDUs and non-IDUs, especially those aged >40 years, seeking HIV testing in HIV CTS associated with substance abuse treatment indicate that HCV counseling and testing should be offered to all clients, regardless of their risk factors. The high rate of HCV infection among non-IDUs could represent an undisclosed history of injection drug use or use only before 1978. Infections in this group may be the result of known risk factors that were not ascertained. A similar finding was observed in a cross-sectional study of persons tested for HCV in drug treatment centers in seven U.S. cities during 1993–1994 (CDC, unpublished data, 2000).

The prevalence of HCV among persons seeking HIV testing in HIV CTS not associated with substance abuse treatment in Connecticut indicates that testing in this setting primarily be guided by a history of risk factors. Among non-IDUs seeking HIV testing in these settings, older age or history of HIV testing may be useful indicators of whether some non-IDUs might benefit from HCV counseling and testing. However, indicators such as age and previous HIV testing might vary across the country and require further study.

Prevalence of Hepatitis C Virus Infection — Continued

TABLE 1. Prevalence of antibody to hepatitis C virus (HCV) among persons tested for HIV at HIV counseling and testing sites not associated with substance abuse treatment, by injection drug user (IDU) status and selected characteristics — Connecticut, April–October 1999

IDU status/ characteristic	No. tested*	HCV positive No.	(%)	Crude rate ratio	Adjusted† rate ratio	(95% CI§)
IDU¶	101	66	(65.3)	18.6		
Age group (yrs)						
18–29	23	7	(30.4)	ref		
30–39	36	26	(72.2)	2.4	2.7**	(1.8– 3.0)
≥40	42	33	(78.6)	2.6	7.7**	(5.7– 9.7)
Race/Ethnicity††						
White, non-Hispanic	57	32	(56.1)	ref		
Black, non-Hispanic	13	9	(69.2)	1.2	1.2	(0.1–21.0)
Hispanic	31	25	(80.6)	1.4	1.6	(0.4– 7.2)
Sex						
Male	69	47	(68.1)	1.1	1.3	(0.4– 4.9)
Female	32	19	(59.4)	ref		
HIV status						
Positive	1	1	(100.0)	1.5	—§§	
Negative	100	65	(65.0)	ref		
NON-IDU	1751	62	(3.5)	ref		
Age group (yrs)						
18–29	866	10	(1.2)	ref		
30–39	506	17	(3.4)	3.0	1.7**	(1.4– 2.0)
≥40	379	35	(9.2)	9.0	3.0**	(2.1– 3.9)
Race/Ethnicity						
White, non-Hispanic	775	21	(2.7)	ref		
Black, non-Hispanic	493	23	(4.7)	1.6	1.3	(0.6– 2.8)
Hispanic	483	18	(3.7)	1.3	0.7	(0.3– 1.7)
Sex						
Male	926	36	(3.9)	1.3	1.3	(0.7– 2.5)
Female	825	26	(3.2)	ref		
HIV status						
Positive	23	4	(17.4)	5.7	2.2	(0.4–11.0)
Negative	1728	58	(3.4)	ref		
Prior HIV test						
Yes	1136	57	(5.0)	5.0	11.9**	(2.8–50.1)
No	615	5	(0.8)	ref		
High school graduate						
No	294	23	(7.8)	2.6	2.5**	(1.3– 5.1)
Yes	855	23	(2.7)	ref		
Income <$10,000/yr						
Yes	521	36	(6.9)	3.5	4.4**	(2.0– 9.6)
No	609	10	(1.6)	ref		
Total	**1852**	**128**	**(6.9)**			

* Numbers may not add to total because of missing data.
† Adjusted for race/ethnicity, sex, age, HIV status, previous HIV test, education, and income.
§ Confidence interval.
¶ Defined as report of self-injection or receipt of an injection with a needle of a nonprescription drug or substance since 1978.
** p<0.05.
†† Numbers for groups other than white, black, and Hispanic were too small for meaningful analysis.
§§ Adjustment using multivariate model not possible because 100% HIV positives in this subgroup were HCV positive.

Prevalence of Hepatitis C Virus Infection — Continued

TABLE 2. Prevalence of antibody to hepatitis C virus (HCV) among persons tested for HIV at HIV counseling and testing sites associated with substance abuse treatment, by injection drug user (IDU) status and selected characteristics — Connecticut, April–October 1999

IDU status/ characteristic	No. tested*	HCV positive No.	HCV positive (%)	Crude rate ratio	Adjusted† rate ratio	(95% CI§)
IDU¶	90	61	(67.8)	4.1		
Age group (yrs)						
18–29	29	14	(48.3)	ref		
30–39	36	26	(72.2)	2.8	3.0**	(2.2– 4.8)
≥40	25	21	(84.0)	5.6	6.5**	(4.4–10.4)
Race/Ethnicity††						
White, non-Hispanic	56	33	(58.9)	ref		
Black, non-Hispanic	2	2	(100.0)	1.7	§§	
Hispanic	32	26	(81.3)	1.4	§§	
Sex						
Male	60	44	(73.3)	1.3	1.9	(0.7– 5.5)
Female	30	17	(56.7)	ref		
HIV status						
Positive	2	1	(50.0)	0.7	0.1	(0.0– 1.9)
Negative	88	60	(68.2)	ref		
Non-IDU	104	17	(16.3)	ref		
Age group (yrs)						
18–29	27	1	(3.7)	ref		
30–39	49	6	(12.2)	3.0	3.3¶	(3.1– 5.2)
≥40	28	10	(35.7)	9.0	11.5¶	(10.6–18.6)
Race/Ethnicity						
White, non-Hispanic	38	5	(13.2)	ref		
Black, non-Hispanic	26	2	(7.7)	0.6	0.5	(0.6– 3.8)
Hispanic	40	10	(25.0)	1.9	3.1	(0.5–20.7)
Sex						
Male	60	6	(10.0)	0.4	0.4	(0.1– 1.6)
Female	44	11	(25.0)	ref		
HIV status						
Positive	1	1	(100.0)	6.3	—¶¶	
Negative	103	16	(15.5)	ref		
Prior HIV test						
Yes	85	16	(18.8)	4.2	2.6	(0.2– 3.1)
No	19	1	(5.3)	ref		
High school graduate						
No	37	5	(13.5)	0.9	0.9	(0.1– 2.0)
Yes	58	9	(15.5)	ref		
Income <$10,000/yr						
Yes	66	10	(15.2)	1.1	1.4	(0.4– 8.9)
No	29	4	(13.8)	ref		
Total	**194**	**78**	**(40.2)**			

* Numbers may not add to total because of missing data.
† Adjusted for race/ethnicity, sex, age, HIV status, previous HIV test, education, and income.
§ Confidence interval.
¶ Defined as report of self-injection or receipt of an injection with a needle of a nonprescription drug or substance since 1978.
** p<0.05.
†† Numbers for groups other than white, black, and Hispanic were too small for meaningful analysis.
§§ Because of small numbers, race/ethnicity was run as a unit in the model and separate rate ratios could not be calculated.
¶¶ Adjustment using multivariate model not possible because of 100% HIV positives in this subgroup being HCV positive.

Prevalence of Hepatitis C Virus Infection — Continued

The findings in this report are subject to at least three limitations. First, because information collected on persons from whom blood samples were taken was based on HIV risk factors, use of injection drugs only after 1978 was considered. Injection drug use before 1978 probably is a risk factor for HCV infection. Second, other potential risk factors (e.g., receipt of a blood transfusion before 1992) were not ascertained. Finally, persons seeking HIV counseling and testing in publicly funded sites in Connecticut may not be representative of persons seeking such services in other states. The rate of HCV infection among IDUs may vary by population and geographic area (*4–7*).

CDC recommends identifying persons at increased risk for HCV infection to provide them with the opportunity for counseling and testing to determine their infection status, for medical evaluation to determine their disease status if infected, and for antiviral therapy if appropriate. Identification of infected persons also provides them with the opportunity to obtain information about preventing further hepatic injury (e.g., not drinking alcohol and getting vaccinated for hepatitis A and B), preventing HCV transmission, and reducing their risk for infection with HIV and hepatitis B virus (HBV).

This study documents the potential for integrating services to prevent major bloodborne and sexually transmitted virus infections into existing public HIV CTS. Risk factors for transmission of these viruses are shared by populations seeking public health services in such sites. Offering HCV counseling and testing as part of existing programs may attract new clients primarily interested in hepatitis screening but who also are at risk for and might accept prevention services for HIV. In addition, HIV CTS can provide hepatitis B vaccination to persons at increased risk for HBV infection (*8*). Because of the well-established infrastructure for HIV counseling and testing in public health programs, expanding these services to include prevention of HCV and HBV infection should be feasible. Health-care providers in HIV CTS should be trained to screen actively for risk factors for HIV, HBV, and HCV and to offer prevention education, counseling, and hepatitis B vaccine to clients with risk factors. In substance abuse treatment settings, data from Connecticut indicate that counseling and testing for HIV and HCV should be provided to all clients.

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Notice to Readers

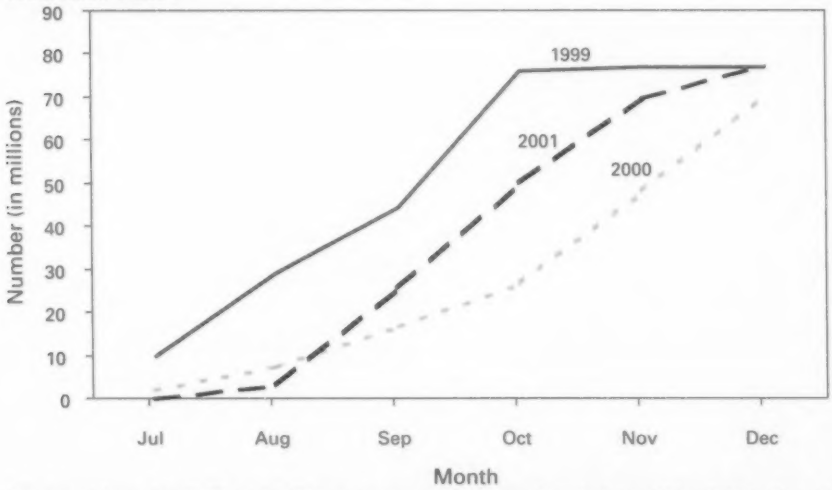
Delayed Influenza Vaccine Availability for 2001–02 Season and Supplemental Recommendations of the Advisory Committee on Immunization Practices

Manufacturer projections of vaccine distribution for the 2001–02 influenza season suggest that 49.8 million doses will be available for delivery by the end of October 2001;* this is approximately 26 million fewer doses of influenza vaccine than were available by the end of October 1999 (75.8 million doses) (Figure 1). Manufacturers also project distribution of 27.3 million doses in November and December, bringing the cumulative projected total to 77.1 million doses, which is greater than in 2000 (70.4) and comparable with 1999 (76.8). Predictions of monthly vaccine distribution vary by manufacturer, and providers will probably receive vaccine on different schedules.

Because of the 2001–02 influenza season vaccine delay and the large number of doses projected for distribution in November and December, the Advisory Committee on

*Manufacturers predict vaccine production based on anticipated demand, production capacity, historic and current experience with yield of vaccine, and duration of production. Accuracy of predictions may be affected by production problems such as strain yields, lot failure, or good manufacturing practices (GMP) issues. One manufacturer that did not produce vaccine in 2000 because of GMP problems has withdrawn from the market.

FIGURE 1. Cumulative number of influenza vaccine doses, by month — United States, 1999, 2000*, 2001†



*The numbers for 1999 and 2000 represent aggregate estimated monthly distribution of influenza vaccine for each of the years represented based on manufacturers' reports.

†The numbers for 2001 are projections and should be used only as a guide that represents the manufacturers' best estimates as of July 10, 2001. The projected estimates could change substantially as production and distribution progress.

Notice to Readers — Continued

Immunization Practices (ACIP) has developed supplemental recommendations. The goals of these recommendations are 1) to prioritize and phase in using vaccine for the 2001–02 influenza season to ensure that persons at greatest risk for severe influenza and its complications and their health-care providers receive vaccine early in the influenza season, and 2) to increase overall protection of those at greatest risk for severe influenza and its complications as targeted in the *Healthy People 2010* objectives (*1*). Persons at high risk include those aged ≥65 years; nursing home and other chronic-care facility residents; adults and children with chronic disorders of the pulmonary and cardiovascular systems, including asthma; adults and children who required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes), renal dysfunction, hemoglobinopathies, or immunosuppression, including that caused by medications or human immunodeficiency virus; children and teenagers (aged 6 months–18 years) who receive long-term aspirin therapy; and women who will be in the second or third trimester of pregnancy during the influenza season (*2*). Achieving influenza vaccination goals will require the combined actions of vaccine providers; the public; manufacturers, distributors, and vendors; and health departments and other organizations providing vaccine.

ACIP Supplemental Recommendations for 2001–02 Influenza Season

Vaccine Providers

- *Providers should target vaccine available in September and October to persons at increased risk for influenza complications and to health-care workers.* The optimal time for vaccinating high-risk persons is October through November (*2*). To avoid missed opportunities, vaccine also should be offered to high-risk persons when they access medical care in September, if vaccine is available. Vaccinating high-risk persons early can be facilitated through reminder and recall systems, in which such patients are identified and encouraged to come into the office for a vaccination-only visit (*3*). Additional information that may help providers implement a reminder/recall system is available at http://www.cdc.gov/nip/flu.
- *Beginning in November, providers should offer vaccine to contacts of high-risk persons, healthy persons aged 50–64 years, and any other persons wanting to reduce their risk for influenza.*
- *Providers should continue vaccinating patients, especially those at high risk and in other target groups (2), in December and should continue as long as there is influenza activity and vaccine is available.* To increase vaccination rates, health-care organizations are encouraged to assess their providers' influenza vaccine use and provide feedback on coverage among persons aged ≥65 years and other high-risk patients (*3*).

The Public

- *Persons at high risk for complications from influenza, including those aged ≥65 years and those aged <65 years who have underlying chronic illnesses, should seek vaccination with their provider when vaccine is available.* The optimal vaccination period is October through November but may include September if vaccine is available. Unvaccinated high-risk persons should continue to seek vaccine later in the season.

Notice to Readers — Continued

- *Persons who are not at high risk for complications from influenza, including household contacts[†] of high-risk persons, are encouraged to seek influenza vaccine in November and later.* Persons who are unsure of their risk status should consult their provider to determine whether they should receive vaccine earlier and, if so, whether vaccine will be available. When additional vaccine is available, providers are encouraged to send a reminder to persons deferred from vaccination.

Manufacturers, Distributors, and Vendors

- *Distribution of vaccine to worksites, where campaigns primarily vaccinate healthy workers, should be delayed until November.* Delaying distribution of vaccine to worksites makes more early-season vaccine available to providers of high-risk patients. Manufacturers and distributors should identify worksite orders, or those placing orders should indicate they are doing so for worksites, so arrangements can be made for later vaccine shipment. Delivery of vaccine to hospitals and chronic-care facilities serving high-risk patients should not be delayed.
- *All providers who have placed orders should receive some early season vaccine.* This strategy will ensure that virtually all providers will be able to vaccinate some of their high-risk patients early in the season. As an exception, complete orders for chronic-care facilities serving high-risk populations should be provided early so that vaccine can be administered in October or November, the optimal time for vaccination of this highest risk group.
- *Manufacturers, distributors, and vendors should inform providers of the amount of vaccine they will be receiving and the date of shipment.* This will allow providers to notify high-risk patients when vaccine will be available.

Health Departments and Other Organizations

- *Organizers of mass vaccination campaigns not in workplaces (e.g., at health departments, clinics, senior centers, and retail stores) should plan campaigns for late October or November or when they are assured of vaccine supply and make special efforts to vaccinate elderly persons and those at high risk for influenza complications.* Information that may be used in a campaign setting is available at http://www.cdc.gov/nip/flu.
- *Influenza vaccine service providers should develop contingency plans for possible delays in vaccine distribution.* In a delay or shortage, communications among partner organizations and potential redirection of vaccine to high-risk persons in the community will be important. State and local health departments can provide guidance that is appropriate for their population and systems of care.

[†]Within a high-risk household, either when the person at risk or the household contact is a young previously unvaccinated child aged <9 years who requires 2-doses for protection, earlier vaccination of contacts may be reasonable; however, this should be a lower priority than vaccination of high-risk persons.

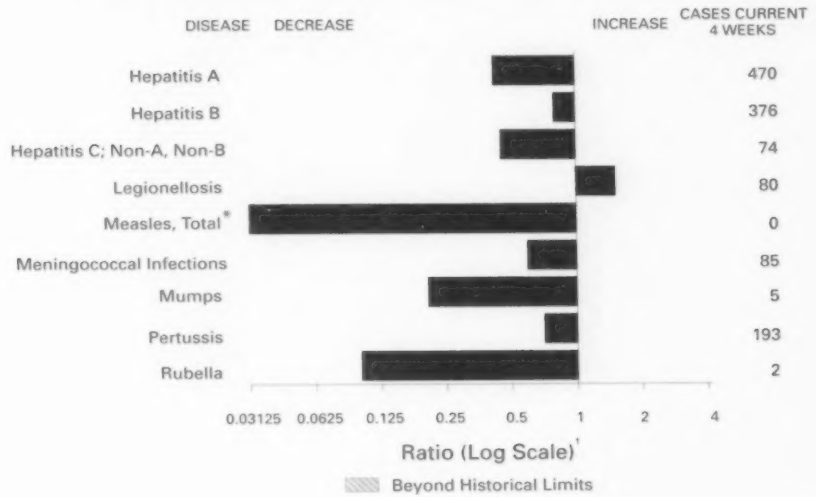
Notice to Readers — Continued

As preparation for the 2001–02 influenza season proceeds, updates on vaccine supply, and other information about influenza vaccination that may be helpful to providers and health departments, will be available at http://www.cdc.gov/nip/flu.

References

1. US Department of Health and Human Services. Healthy people 2010 (conference ed., in 2 vols). Washington, DC: US Department of Health and Human Services, 2000.
2. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2001;50(no. RR-4).
3. Task Force on Community Preventive Services. Recommendations regarding interventions to improve vaccination coverage in children, adolescents, and adults. Am J Prev Med 2000;18:92–6.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending July 7, 2001, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 27 of zero (0).

† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending July 7, 2001 (27th Week)

	Cum. 2001		Cum. 2001
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	35	Psittacosis*	7
Cholera	3	Q fever*	9
Cyclosporiasis*	54	Rabies, human	-
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	174
Ehrlichiosis: human granulocytic (HGE)*	43	Rubella, congenital syndrome	-
human monocytic (HME)*	23	Streptococcal disease, invasive, group A	1,969
Encephalitis: California serogroup viral*	1	Streptococcal toxic-shock syndrome*	33
eastern equine*	1	Syphilis, congenital†	84
St. Louis*	-	Tetanus	12
western equine*	-	Toxic-shock syndrome	63
Hansen disease (leprosy)*	31	Trichinosis	11
Hantavirus pulmonary syndrome*†	4	Tularemia*	37
Hemolytic uremic syndrome, postdiarrheal*	42	Typhoid fever	125
HIV infection, pediatric*†	98	Yellow fever	-
Plague	2		

-: No reported cases.
* Not notifiable in all states.
† Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update June 26, 2001.
† Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending July 7, 2001, and July 8, 2000 (27th Week)

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2001§	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	19,145	20,040	336,922	351,599	836	801	811	1,317	579	1,212
NEW ENGLAND	746	1,197	11,730	11,773	35	46	101	133	66	147
Maine	20	16	636	713	3	9	12	7	12	14
N.H.	17	17	660	522	2	4	14	9	9	13
Vt.	10	17	308	276	13	13	4	8	2	15
Mass.	411	763	5,386	5,018	10	13	41	66	28	57
R.I.	53	48	1,431	1,294	3	2	5	8	4	8
Conn.	235	336	3,309	3,950	4	5	25	35	11	40
MID. ATLANTIC	3,974	4,819	38,310	33,526	94	146	64	150	49	113
Upstate N.Y.	322	538	6,554	559	42	37	50	99	33	38
N.Y. City	1,996	2,608	14,967	14,167	46	81	4	10	3	8
N.J.	960	985	5,078	6,461	3	6	10	41	13	38
Pa.	696	688	11,711	12,339	3	22	N	N	-	29
E.N. CENTRAL	1,408	2,013	48,969	60,321	265	182	188	263	129	197
Ohio	237	289	7,148	15,966	55	23	56	40	38	43
Ind.	165	188	7,566	6,608	29	12	30	29	18	34
Ill.	665	1,191	12,915	17,293	1	27	38	76	28	57
Mich.	261	254	15,522	12,069	69	28	25	39	23	35
Wis.	80	91	5,818	8,385	111	92	40	79	22	28
W.N. CENTRAL	454	480	17,411	19,949	80	59	101	168	97	202
Minn.	86	86	3,185	4,059	32	11	30	40	47	61
Iowa	47	52	1,858	2,719	23	18	19	29	7	32
Mo.	218	225	6,369	6,800	8	8	19	47	24	46
N. Dak.	1	1	501	462	3	5	1	7	8	13
S. Dak.	18	4	920	914	5	5	7	10	5	15
Nebr.	39	31	1,594	1,925	9	9	15	23	-	26
Kans.	46	81	2,984	3,070	-	3	10	12	6	9
S. ATLANTIC	6,167	5,299	63,067	65,195	152	124	86	101	41	95
Del.	116	94	1,491	1,480	1	4	1	1	3	-
Md.	751	597	6,156	6,884	26	6	6	12	1	1
D.C.	465	388	1,663	1,677	9	5	-	-	U	U
Va.	501	358	9,002	8,249	9	4	20	22	15	25
W. Va.	49	31	1,204	1,113	1	3	3	7	-	3
N.C.	402	311	8,692	11,454	16	11	26	19	11	24
S.C.	350	409	5,757	4,855	-	-	2	6	2	7
Ga.	757	605	11,883	13,035	53	61	13	13	2	15
Fla.	2,776	2,506	17,219	16,448	37	30	15	21	7	20
E.S. CENTRAL	977	966	24,913	25,433	19	25	39	51	30	44
Ky.	201	113	4,552	4,167	3	1	14	18	16	16
Tenn.	293	381	7,502	7,328	3	6	18	19	12	22
Ala.	224	255	7,170	7,699	6	10	6	5	-	4
Miss.	259	217	5,689	6,239	7	8	1	9	2	2
W.S. CENTRAL	2,058	1,837	53,026	53,197	18	41	34	142	49	171
Ark.	104	101	3,823	3,242	3	1	3	35	-	30
La.	472	318	8,709	9,809	7	9	2	10	20	25
Okla.	107	161	5,636	4,340	6	4	12	9	14	7
Tex.	1,375	1,257	34,858	35,806	2	27	17	88	15	109
MOUNTAIN	714	725	17,841	20,797	57	40	86	129	52	105
Mont.	12	9	1,015	802	5	8	5	15	-	-
Idaho	15	13	882	966	7	3	13	14	-	12
Wyo.	1	6	414	410	1	5	3	9	1	6
Colo.	140	157	1,798	6,197	17	11	35	50	26	38
N. Mex.	56	86	3,025	2,568	11	1	7	3	4	5
Ariz.	295	224	7,455	6,586	3	2	11	24	9	20
Utah	63	62	772	1,310	11	8	6	12	11	19
Nev.	132	168	2,480	1,958	2	2	6	2	1	5
PACIFIC	2,647	2,704	61,655	61,408	116	138	112	180	66	138
Wash.	290	275	7,066	6,635	N	U	29	58	13	77
Oreg.	112	88	1,841	3,659	10	9	20	30	14	35
Calif.	2,204	2,252	50,725	48,051	103	129	58	82	37	18
Alaska	13	10	1,294	1,266	-	-	2	2	-	1
Hawaii	28	79	729	1,797	3	-	3	8	2	7
Guam	9	13	-	251	-	-	N	N	U	U
P.R.	580	516	1,510	U	-	-	-	5	U	U
V.I.	2	21	53	-	-	-	-	-	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	60	U	-	U	-	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

† Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update June 26, 2001.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending July 7, 2001, and July 8, 2000 (27th Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	153,534	174,933	1,130	1,752	378	403	202	2,023	5,457
NEW ENGLAND	3,224	3,271	14	14	19	25	24	635	1,333
Maine	70	42	-	1	1	2	-	-	-
N.H.	78	54	-	-	5	2	-	60	36
Vt.	39	30	6	3	4	2	-	3	12
Mass.	1,650	1,308	8	7	4	11	13	112	547
R.I.	360	315	-	3	1	3	1	63	56
Conn.	1,027	1,522	-	-	4	5	10	397	682
MID. ATLANTIC	17,915	18,672	43	381	42	105	30	859	3,161
Upstate N.Y.	4,068	3,395	30	17	28	31	13	673	834
N.Y. City	6,282	5,903	-	-	4	16	5	1	124
N.J.	1,879	3,675	-	339	5	9	7	84	1,410
Pa.	5,686	5,699	13	25	5	49	5	101	793
E.N. CENTRAL	26,095	35,428	107	135	107	104	25	86	365
Ohio	4,254	9,198	7	4	56	38	6	43	20
Ind.	3,130	3,031	1	-	10	16	4	2	6
Ill.	7,742	10,548	10	15	-	11	-	-	24
Mich.	9,027	9,106	89	116	27	20	13	-	10
Wis.	1,942	3,545	-	-	14	19	2	41	305
W.N. CENTRAL	7,208	8,613	412	304	30	22	6	67	63
Minn.	1,015	1,634	2	5	6	1	-	39	24
Iowa	428	576	-	1	6	4	-	11	2
Mo.	3,783	4,173	405	292	10	12	3	12	22
N. Dak.	16	36	-	-	1	-	-	-	-
S. Dak.	141	137	-	-	2	1	-	-	-
Nebr.	543	730	1	2	4	1	1	2	2
Kans.	1,282	1,328	4	4	1	3	2	3	13
S. ATLANTIC	38,964	45,546	55	46	71	70	32	294	438
Del.	846	830	-	2	1	4	-	20	90
Md.	3,327	4,556	9	4	19	21	3	184	266
D.C.	1,468	1,183	-	2	2	-	-	7	1
Va.	4,845	5,073	-	1	9	12	5	57	53
W. Va.	318	343	6	9	N	N	4	4	10
N.C.	7,854	9,315	10	13	5	8	1	8	11
S.C.	4,140	4,723	4	1	1	2	2	2	2
Ga.	6,423	8,121	-	2	6	4	8	-	-
Fla.	9,743	11,402	26	12	28	19	9	12	5
E.S. CENTRAL	15,961	18,038	118	254	34	13	9	13	18
Ky.	1,754	1,740	4	17	9	6	3	4	4
Tenn.	4,926	5,705	36	58	15	4	3	6	11
Ala.	5,628	6,001	2	7	8	2	3	3	2
Miss.	3,653	4,592	77	172	2	1	-	-	1
W.S. CENTRAL	25,610	27,547	161	492	5	18	5	7	28
Ark.	2,349	1,698	3	4	-	-	1	-	-
La.	6,073	6,895	74	260	2	7	-	1	3
Okla.	2,542	1,869	3	4	3	1	1	-	-
Tex.	14,646	17,085	81	224	-	10	3	6	25
MOUNTAIN	5,249	5,329	142	38	29	17	22	5	2
Mont.	53	26	1	2	-	-	-	-	-
Idaho	38	49	1	3	1	3	1	2	-
Wyo.	32	30	102	2	1	-	1	1	1
Colo.	1,612	1,634	13	6	9	6	3	1	-
N. Mex.	485	545	10	10	1	1	5	-	-
Ariz.	2,072	2,196	9	11	11	2	6	-	-
Utah	66	135	1	-	4	5	1	-	-
Nev.	892	714	5	4	2	-	5	1	1
PACIFIC	13,308	12,489	78	88	41	29	49	57	49
Wash.	1,508	1,152	16	14	6	10	3	2	3
Oreg.	263	475	8	17	N	N	1	5	3
Calif.	11,189	10,453	54	55	34	19	44	50	42
Alaska	181	175	-	-	-	-	-	-	1
Hawaii	167	234	-	2	1	-	1	N	N
Guam	-	26	-	2	-	-	-	-	-
P.R.	413	277	1	1	2	-	-	N	N
V.I.	6	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	4	U	-	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending July 7, 2001, and July 8, 2000 (27th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	462	613	2,985	3,398	13,637	16,174	10,840	14,376
NEW ENGLAND	32	23	316	371	1,114	993	958	1,043
Maine	3	4	36	73	106	67	78	61
N.H.	2	1	7	8	90	64	94	68
Vt.	-	2	37	34	36	57	38	58
Mass.	9	10	108	119	616	603	460	579
R.I.	3	4	29	16	59	40	79	72
Conn.	15	2	99	121	208	162	209	205
MID. ATLANTIC	82	144	448	588	1,451	2,358	1,802	2,431
Upstate N.Y.	22	29	346	354	499	530	479	618
N.Y. City	40	74	11	5	434	609	558	635
N.J.	14	21	84	80	343	587	344	456
Pa.	6	20	7	149	175	632	421	722
E.N. CENTRAL	50	76	38	42	1,958	2,276	1,482	1,411
Ohio	12	12	14	9	661	541	483	513
Ind.	11	3	1	-	194	257	188	279
Ill.	1	39	4	4	456	737	302	1
Mich.	18	15	13	20	364	425	313	451
Wis.	8	7	6	9	283	316	196	167
W.N. CENTRAL	19	28	176	303	837	1,041	862	1,185
Minn.	6	8	18	48	211	229	306	314
Iowa	3	1	39	43	143	135	95	157
Mo.	6	6	14	16	240	343	296	400
N. Dak.	-	2	24	74	14	27	29	41
S. Dak.	-	-	21	61	60	37	50	49
Nebr.	2	5	4	-	59	98	-	78
Kans.	2	6	56	61	110	172	86	146
S. ATLANTIC	133	131	1,097	1,204	3,255	2,811	1,951	2,436
Del.	1	3	18	20	37	51	43	64
Md.	56	44	138	232	348	359	352	340
D.C.	9	8	-	-	33	29	U	U
Va.	28	28	222	302	551	385	400	407
W. Va.	1	2	69	63	52	65	55	67
N.C.	3	11	299	297	479	386	272	421
S.C.	4	1	68	68	331	272	291	217
Ga.	8	4	174	157	492	434	351	703
Fla.	23	30	109	65	932	830	187	217
E.S. CENTRAL	11	20	106	96	821	826	499	659
Ky.	2	6	11	14	151	170	99	123
Tenn.	6	5	71	50	237	196	239	287
Ala.	3	8	24	32	251	217	109	208
Miss.	-	1	-	-	182	243	52	41
W.S. CENTRAL	6	38	502	510	1,155	1,971	1,026	1,189
Ark.	3	1	19	-	234	220	92	168
La.	1	6	-	1	249	339	297	255
Okla.	1	4	41	35	126	151	126	127
Tex.	1	27	442	474	546	1,261	511	639
MOUNTAIN	26	23	115	124	943	1,265	685	1,190
Mont.	2	1	18	34	37	58	-	-
Idaho	3	1	2	1	62	69	4	62
Wyo.	-	-	17	33	30	33	22	28
Colo.	12	11	-	-	262	378	236	365
N. Mex.	1	-	4	10	120	112	88	110
Ariz.	3	3	72	43	262	297	216	306
Utah	3	3	1	2	104	187	96	198
Nev.	2	4	1	1	66	131	23	121
PACIFIC	103	130	187	160	2,103	2,633	1,575	2,832
Wash.	4	12	-	-	217	214	205	308
Oreg.	5	22	-	2	100	161	142	209
Calif.	89	89	154	134	1,674	2,133	1,068	2,197
Alaska	1	-	33	24	21	29	2	22
Hawaii	4	7	-	-	91	96	158	96
Guam	-	-	-	-	-	15	U	U
P.R.	3	4	59	39	287	277	U	U
V.I.	-	-	-	-	-	-	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	5	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending July 7, 2001, and July 8, 2000 (27th Week)

Reporting Area	Shigellosis*				Syphilis (Primary & Secondary)		Tuberculosis	
	NETSS		PHLIS					
	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	6,724	10,133	3,177	5,618	2,787	3,149	5,799	7,018
NEW ENGLAND	110	180	102	168	27	46	212	203
Maine	4	5	1	-	-	1	7	8
N.H.	2	3	2	6	1	1	11	6
Vt.	3	1	2	-	2	-	2	3
Mass.	72	131	63	117	16	30	117	116
R.I.	8	12	12	16	3	3	21	23
Conn.	21	28	22	29	5	11	54	47
MID. ATLANTIC	578	1,442	452	898	245	159	1,150	1,150
Upstate N.Y.	308	419	64	152	17	6	157	140
N.Y. City	176	640	223	415	129	67	601	608
N.J.	40	252	100	209	49	35	259	278
Pa.	54	131	65	122	50	51	133	124
E.N. CENTRAL	1,199	2,116	497	646	470	652	614	680
Ohio	633	141	239	110	45	37	101	149
Ind.	119	759	20	97	97	214	49	70
Ill.	195	601	117	2	110	234	313	309
Mich.	150	431	107	402	202	136	116	106
Wis.	102	184	14	35	16	31	35	46
W.N. CENTRAL	739	970	504	800	35	42	210	254
Minn.	217	255	252	286	17	5	106	82
Iowa	210	222	84	183	1	10	18	23
Mo.	139	366	96	256	8	22	55	94
N. Dak.	13	4	5	4	-	-	3	2
S. Dak.	84	2	48	2	-	-	8	9
Nebr.	34	37	-	26	1	2	20	11
Kans.	42	84	19	43	8	3	-	33
S. ATLANTIC	1,041	1,198	281	469	1,028	1,036	1,186	1,448
Del.	4	8	4	9	7	5	9	3
Md.	54	65	31	30	119	151	100	132
D.C.	23	16	U	U	21	21	15	8
Va.	103	199	38	177	64	69	114	140
W. Va.	5	3	6	3	-	2	15	18
N.C.	196	64	78	37	243	299	181	194
S.C.	126	63	48	52	135	109	117	150
Ga.	117	121	57	98	147	188	234	299
Fla.	413	659	19	63	292	192	401	504
E.S. CENTRAL	681	482	276	302	306	467	370	468
Ky.	270	139	134	47	23	51	60	58
Tenn.	48	209	48	230	173	286	128	177
Ala.	126	28	78	22	56	63	134	152
Miss.	237	106	16	3	54	67	48	81
W.S. CENTRAL	978	1,673	680	487	354	415	651	1,059
Ark.	347	104	155	36	21	50	68	110
La.	108	156	103	88	69	100	-	71
Okla.	20	61	10	20	35	66	71	76
Tex.	503	1,352	412	343	229	199	512	802
MOUNTAIN	399	456	231	295	121	114	190	250
Mont.	-	4	-	-	-	-	-	6
Idaho	18	30	-	21	-	1	4	4
Wyo.	-	2	-	2	-	1	1	1
Colo.	77	81	65	42	23	5	55	38
N. Mex.	59	44	35	26	10	10	11	28
Ariz.	188	183	99	110	78	92	72	96
Utah	25	36	24	40	6	1	12	24
Nev.	32	76	8	54	4	4	35	53
PACIFIC	999	1,616	154	1,553	201	218	1,216	1,506
Wash.	91	317	76	281	31	35	113	128
Oreg.	33	97	51	62	4	8	48	47
Calif.	857	1,173	-	1,188	163	174	1,010	1,199
Alaska	3	6	1	3	-	-	22	62
Hawaii	15	23	26	19	3	1	23	70
Guam	-	22	U	U	-	2	-	30
P.R.	6	17	U	U	111	95	54	70
V.I.	-	-	U	U	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	4	U	U	U	-	U	19	U

N: Not notifiable. U: Unavailable. -: No reported cases.

*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending July 7, 2001, and July 8, 2000 (27th Week)

Reporting Area	*H. influenzae*, Invasive		Hepatitis (Viral), By Type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2001†	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	737	719	4,660	6,572	3,155	3,558	-	42	-	25	67	53
NEW ENGLAND	42	57	220	182	45	58	-	4	-	1	5	3
Maine	1	1	5	10	5	5	-	-	-	-	-	-
N.H.	-	9	7	16	11	10	-	-	-	-	-	-
Vt.	1	4	6	4	2	5	-	1	-	-	1	3
Mass.	32	29	66	75	3	5	-	2	-	1	3	-
R.I.	2	1	10	7	12	9	-	-	-	-	-	-
Conn.	6	13	127	70	12	24	-	1	-	-	1	-
MID. ATLANTIC	91	133	401	683	439	613	-	2	-	5	7	18
Upstate N.Y.	40	49	132	110	74	62	-	1	-	4	5	7
N.Y. City	24	37	168	256	258	292	-	-	-	-	-	10
N.J.	25	27	70	116	64	104	-	-	-	1	1	-
Pa.	2	20	31	201	43	155	-	1	-	-	1	1
E.N. CENTRAL	99	108	516	846	394	381	-	-	-	10	10	6
Ohio	47	35	125	144	62	65	-	-	-	3	3	2
Ind.	26	11	44	27	21	26	-	-	-	4	4	-
Ill.	10	40	144	365	56	59	-	-	-	3	3	3
Mich.	6	7	165	263	255	214	-	-	-	-	-	1
Wis.	10	15	38	47	-	17	-	-	-	-	-	-
W.N. CENTRAL	34	34	207	453	109	157	-	4	-	-	4	1
Minn.	18	16	14	123	13	19	U	2	U	-	2	1
Iowa	-	-	18	44	13	15	-	-	-	-	-	-
Mo.	10	11	57	200	56	83	-	2	-	-	2	-
N. Dak.	4	2	2	2	-	2	-	-	-	-	-	-
S. Dak.	-	-	1	-	1	-	-	-	-	-	-	-
Nebr.	1	3	26	19	13	24	-	-	-	-	-	-
Kans.	1	2	89	65	13	14	-	-	-	-	-	-
S. ATLANTIC	235	167	1,033	673	686	605	-	3	-	1	4	-
Del.	-	-	-	10	-	8	-	-	-	-	-	-
Md.	55	47	134	77	81	72	-	2	-	1	3	-
D.C.	-	-	21	13	8	17	-	-	-	-	-	-
Va.	18	28	68	77	78	77	-	-	-	-	-	-
W. Va.	8	4	7	44	16	6	-	-	-	-	-	-
N.C.	30	15	72	92	109	139	-	-	-	-	-	-
S.C.	5	5	30	30	13	5	U	-	U	-	-	-
Ga.	60	47	421	111	174	98	-	1	-	-	1	-
Fla.	59	21	280	219	207	183	-	-	-	-	-	-
E.S. CENTRAL	56	33	175	245	212	250	-	2	-	-	2	-
Ky.	2	12	36	30	17	53	-	2	-	-	2	-
Tenn.	28	14	74	91	110	111	-	-	-	-	-	-
Ala.	25	5	57	32	46	26	-	-	-	-	-	-
Miss.	1	2	8	92	39	60	-	-	-	-	-	-
W.S. CENTRAL	27	41	596	1,198	352	535	-	1	-	-	1	-
Ark.	-	-	34	90	54	60	-	-	-	-	-	-
La.	3	12	46	44	27	82	-	-	-	-	-	-
Okla.	24	27	83	147	59	67	-	-	-	-	-	-
Tex.	-	2	433	917	212	326	-	1	-	-	1	-
MOUNTAIN	98	74	434	448	296	258	-	-	-	1	1	12
Mont.	-	-	6	2	2	3	U	-	U	-	-	-
Idaho	1	3	45	17	7	4	-	-	-	1	1	-
Wyo.	4	1	16	4	16	-	-	-	-	-	-	-
Colo.	23	14	37	102	62	46	-	-	-	-	-	2
N. Mex.	13	16	17	40	77	82	-	-	-	-	-	-
Ariz.	42	31	233	217	96	86	-	-	-	-	-	-
Utah	6	6	40	31	14	14	-	-	-	-	-	3
Nev.	9	3	40	35	22	23	-	-	-	-	-	7
PACIFIC	55	72	1,078	1,844	622	701	-	26	-	7	33	13
Wash.	1	3	53	153	67	43	-	13	-	2	15	3
Oreg.	15	21	41	121	38	56	-	3	-	-	3	-
Calif.	32	27	972	1,549	509	590	-	8	-	4	12	7
Alaska	3	3	12	10	4	5	-	-	-	-	-	1
Hawaii	4	18	-	11	4	7	-	2	-	1	3	2
Guam	-	1	-	1	-	9	U	-	U	-	-	-
P.R.	1	3	54	165	93	139	-	-	-	-	-	2
V.I.	-	-	-	-	-	-	U	-	U	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	19	U	U	-	U	-	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

*For imported measles, cases include only those resulting from importation from other countries.

† Of 155 cases among children aged <5 years, serotype was reported for 70, and of those, 11 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending July 7, 2001, and July 8, 2000 (27th Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	1,329	1,332	1	88	199	49	2,207	2,885	-	13	95
NEW ENGLAND	78	80	-	-	3	2	242	799	-	-	11
Maine	1	6	-	-	-	-	-	14	-	-	-
N.H.	10	9	-	-	-	-	21	62	-	-	2
Vt.	4	2	-	-	-	1	24	153	-	-	-
Mass.	44	47	-	-	1	1	181	532	-	-	8
R.I.	2	5	-	-	1	-	2	9	-	-	-
Conn.	17	11	-	-	1	-	14	29	-	-	1
MID. ATLANTIC	109	148	-	5	13	3	143	244	-	4	8
Upstate N.Y.	42	38	-	1	5	3	103	130	-	1	1
N.Y. City	28	32	-	4	5	-	23	40	-	2	7
N.J.	31	27	-	-	-	-	8	-	-	1	-
Pa.	8	51	-	-	3	-	9	74	-	-	-
E.N. CENTRAL	164	233	-	12	17	14	269	312	-	3	1
Ohio	57	49	-	1	7	10	167	165	-	-	-
Ind.	26	30	-	1	-	3	23	27	-	1	-
Ill.	20	60	-	8	5	-	28	23	-	2	1
Mich.	30	71	-	2	4	1	27	36	-	-	-
Wis.	31	23	-	-	1	-	24	61	-	-	-
W.N. CENTRAL	99	87	-	5	10	1	115	142	-	2	1
Minn.	14	7	U	2	-	U	31	65	U	-	-
Iowa	20	19	-	-	5	-	16	23	-	1	-
Mo.	38	44	-	-	2	-	49	25	-	-	-
N. Dak.	5	2	-	-	-	-	-	1	-	-	-
S. Dak.	4	5	-	-	-	-	3	3	-	-	-
Nebr.	9	4	-	1	1	1	3	3	-	-	1
Kans.	9	6	-	2	2	-	13	22	-	1	-
S. ATLANTIC	251	186	1	18	29	1	116	210	-	3	50
Del.	1	-	-	-	-	-	-	5	-	-	-
Md.	31	19	-	4	6	-	18	53	-	-	-
D.C.	-	-	-	-	-	-	1	1	-	-	-
Va.	26	30	-	2	5	-	12	21	-	-	-
W. Va.	6	8	-	-	-	-	1	1	-	-	-
N.C.	56	29	-	1	4	-	40	51	-	-	42
S.C.	24	15	U	1	9	U	22	19	U	2	6
Ga.	34	33	-	7	2	-	6	20	-	-	-
Fla.	74	52	1	3	3	1	16	39	-	1	2
E.S. CENTRAL	90	93	-	3	4	3	48	60	-	-	4
Ky.	14	19	-	1	-	-	11	31	-	-	1
Tenn.	39	39	-	-	2	2	20	15	-	-	-
Ala.	29	26	-	-	2	1	14	11	-	-	3
Miss.	8	9	-	2	-	-	3	3	-	-	-
W.S. CENTRAL	163	143	-	7	22	4	157	134	-	-	6
Ark.	10	8	-	1	1	-	7	14	-	-	1
La.	53	34	-	2	4	-	2	8	-	-	1
Okla.	20	21	-	-	-	-	1	9	-	-	-
Tex.	80	80	-	4	17	4	147	103	-	-	4
MOUNTAIN	71	60	-	7	13	10	887	387	-	-	2
Mont.	2	1	U	-	1	U	9	9	U	-	-
Idaho	7	6	-	-	-	1	165	41	-	-	-
Wyo.	5	-	-	1	1	-	1	1	-	-	-
Colo.	25	20	-	1	-	7	159	217	-	-	1
N. Mex.	10	6	-	2	1	2	60	67	-	-	-
Ariz.	11	18	-	1	3	-	460	35	-	-	1
Utah	7	6	-	1	4	-	24	11	-	-	-
Nev.	4	3	-	1	3	-	9	6	-	-	-
PACIFIC	304	302	-	31	88	11	230	597	-	1	12
Wash.	45	31	-	1	2	10	79	192	-	-	7
Oreg.	21	36	N	N	N	1	24	58	-	-	-
Calif.	234	223	-	24	69	-	120	312	-	-	5
Alaska	2	5	-	1	7	-	1	11	-	-	-
Hawaii	2	8	-	5	10	-	6	24	-	1	-
Guam	-	-	U	-	9	U	-	3	U	-	1
P.R.	3	7	-	-	-	-	2	4	-	-	-
V.I.	-	-	U	-	-	U	-	-	U	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	U	-	U	U	-	U	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

TABLE IV. Deaths in 122 U.S. cities,* week ending July 7, 2001 (27th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	65	45-64	25-44	1-24	<1	
NEW ENGLAND	528	363	100	39	18	8	44
Boston, Mass.	179	118	36	10	10	5	17
Bridgeport, Conn.	36	28	7	-	1	-	2
Cambridge, Mass.	14	9	4	-	1	-	-
Fall River, Mass.	17	17	-	-	-	-	2
Hartford, Conn.	65	31	20	10	3	1	2
Lowell, Mass.	23	14	3	6	-	-	2
Lynn, Mass.	6	4	2	-	-	-	1
New Bedford, Mass.	28	26	2	-	-	-	1
New Haven, Conn.	35	23	7	4	1	-	4
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	3	3	-	-	-	-	-
Springfield, Mass.	38	24	6	6	2	-	5
Waterbury, Conn.	30	24	3	2	-	1	1
Worcester, Mass.	54	42	10	1	-	1	7
MID. ATLANTIC	1,948	1,367	380	143	41	17	91
Albany, N.Y.	31	25	6	-	-	-	5
Allentown, Pa.	18	16	1	1	-	-	-
Buffalo, N.Y.	80	55	19	5	-	1	10
Camden, N.J.	36	17	8	4	3	4	1
Elizabeth, N.J.	11	8	3	-	-	-	-
Erie, Pa.[†]	44	30	12	-	1	1	1
Jersey City, N.J.	44	32	8	3	1	-	-
New York City, N.Y.	1,015	706	200	82	21	6	34
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	25	15	7	3	-	-	-
Philadelphia, Pa.	301	199	66	26	6	4	15
Pittsburgh, Pa.[§]	42	32	5	3	1	1	4
Reading, Pa.	23	19	3	-	1	-	1
Rochester, N.Y.	115	83	22	7	3	-	10
Schenectady, N.Y.	22	20	1	1	-	-	1
Scranton, Pa.[§]	33	29	2	1	1	-	-
Syracuse, N.Y.	64	50	11	3	-	-	6
Trenton, N.J.	22	15	2	2	3	-	1
Utica, N.Y.	22	16	4	2	-	-	2
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,341	917	280	91	27	26	94
Akron, Ohio	53	37	11	3	-	2	7
Canton, Ohio	31	21	8	1	-	1	2
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	58	43	6	6	2	1	9
Cleveland, Ohio	126	79	29	11	4	3	7
Columbus, Ohio	122	77	29	9	3	4	11
Dayton, Ohio	95	65	22	5	3	-	5
Detroit, Mich.	186	109	53	16	5	3	15
Evansville, Ind.	37	29	4	2	-	2	6
Fort Wayne, Ind.	61	43	12	4	2	-	-
Gary, Ind.	22	15	5	1	-	1	-
Grand Rapids, Mich.	42	30	10	1	1	-	5
Indianapolis, Ind.	132	84	33	9	3	3	8
Lansing, Mich.	23	16	5	2	-	-	1
Milwaukee, Wis.	99	71	15	10	1	2	5
Peoria, Ill.	55	41	12	2	-	-	4
Rockford, Ill.	27	18	4	3	1	1	1
South Bend, Ind.	44	41	1	-	1	1	2
Toledo, Ohio	81	56	17	5	1	2	5
Youngstown, Ohio	47	42	4	1	-	-	1
W.N. CENTRAL	504	377	84	22	8	13	28
Des Moines, Iowa	66	52	7	4	-	3	3
Duluth, Minn.	17	14	3	-	-	-	-
Kansas City, Kans.	U	U	U	U	U	U	U
Kansas City, Mo.	90	61	15	7	2	5	6
Lincoln, Nebr.	25	20	3	1	-	1	2
Minneapolis, Minn.	122	90	24	4	3	1	6
Omaha, Nebr.	63	50	10	1	1	1	4
St. Louis, Mo.	69	49	13	5	2	-	2
St. Paul, Minn.	52	41	9	-	-	2	5
Wichita, Kans.	U	U	U	U	U	U	U
S. ATLANTIC	1,149	734	251	104	39	19	62
Atlanta, Ga.	114	64	33	13	3	1	-
Baltimore, Md.	167	96	36	22	10	3	12
Charlotte, N.C.	74	51	13	10	-	-	11
Jacksonville, Fla.	125	88	24	11	2	-	9
Miami, Fla.	87	62	16	2	1	5	10
Norfolk, Va.	54	30	16	4	2	2	-
Richmond, Va.	48	24	13	6	2	3	1
Savannah, Ga.	59	40	12	3	3	1	6
St. Petersburg, Fla.	48	36	8	3	1	-	3
Tampa, Fla.	151	111	26	10	3	1	6
Washington, D.C.	200	115	52	17	12	3	4
Wilmington, Del.	22	17	2	3	-	-	-
E.S. CENTRAL	745	493	164	51	20	17	45
Birmingham, Ala.	126	86	22	6	4	8	9
Chattanooga, Tenn.	60	37	15	6	1	1	4
Knoxville, Tenn.	68	52	9	5	2	-	8
Lexington, Ky.	51	35	12	2	2	-	3
Memphis, Tenn.	218	142	52	16	4	4	13
Mobile, Ala.	77	47	22	4	4	-	4
Montgomery, Ala.	37	25	9	2	1	-	3
Nashville, Tenn.	108	69	23	10	2	4	1
W.S. CENTRAL	1,250	790	256	114	48	42	76
Austin, Tex.	90	57	23	1	5	4	4
Baton Rouge, La.	71	49	13	9	-	-	3
Corpus Christi, Tex.	40	28	5	3	1	3	1
Dallas, Tex.	165	95	33	22	6	9	16
El Paso, Tex.	68	54	9	3	1	1	5
Ft. Worth, Tex.	79	56	14	4	1	4	1
Houston, Tex.	303	176	56	37	22	12	18
Little Rock, Ark.	50	29	13	2	1	5	1
New Orleans, La.	64	24	26	8	5	1	2
San Antonio, Tex.	174	115	36	19	2	2	12
Shreveport, La.	63	49	9	2	2	1	9
Tulsa, Okla.	83	58	19	4	2	-	4
MOUNTAIN	829	566	159	65	23	15	56
Albuquerque, N.M.	90	64	10	11	3	2	6
Boise, Idaho	41	27	10	2	1	1	4
Colo. Springs, Colo.	40	19	14	3	3	1	1
Denver, Colo.	112	78	19	9	3	3	15
Las Vegas, Nev.	199	135	46	11	5	2	11
Ogden, Utah	24	19	3	2	-	-	1
Phoenix, Ariz.	119	80	15	16	4	4	6
Pueblo, Colo.	26	19	4	2	1	-	1
Salt Lake City, Utah	99	76	17	3	1	2	7
Tucson, Ariz.	79	49	21	6	2	-	4
PACIFIC	1,370	1,003	247	68	22	26	132
Berkeley, Calif.	19	13	5	-	-	1	2
Fresno, Calif.	61	46	12	3	-	-	3
Glendale, Calif.	14	11	2	-	-	1	3
Honolulu, Hawaii	58	45	10	2	-	1	5
Long Beach, Calif.	70	54	11	4	-	1	11
Los Angeles, Calif.	308	231	53	15	5	4	20
Pasadena, Calif.	31	24	5	1	1	-	6
Portland, Oreg.	89	69	13	4	-	3	6
Sacramento, Calif.	167	114	34	9	5	5	29
San Diego, Calif.	130	89	26	7	3	4	13
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	173	133	29	6	4	1	13
Santa Cruz, Calif.	25	15	8	-	-	2	-
Seattle, Wash.	88	54	20	9	3	2	7
Spokane, Wash.	48	38	7	1	1	1	9
Tacoma, Wash.	89	67	12	7	-	-	5
TOTAL	9,664[¶]	6,610	1,921	697	246	183	628

U: Unavailable. -:No reported cases.
*Mortality data in this table are voluntarily reported from 122 cities in the United States, most of which have populations of ≥100,000. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.
†Pneumonia and influenza.
§Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.
¶Total includes unknown ages.

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